The CQUIN Learning Network

Patients at High Risk:
Experience, Guidelines, and Best Practices in Kenya

Dr. Maureen Kimani
Ministry of Health- National AIDS/STI Control Program (NASCOP)

July 17-19, 2017
Harare, Zimbabwe

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Care

ICAP
GLOBAL. HEALTH. ACTION.
Columbia University
Mailman School of Public Health

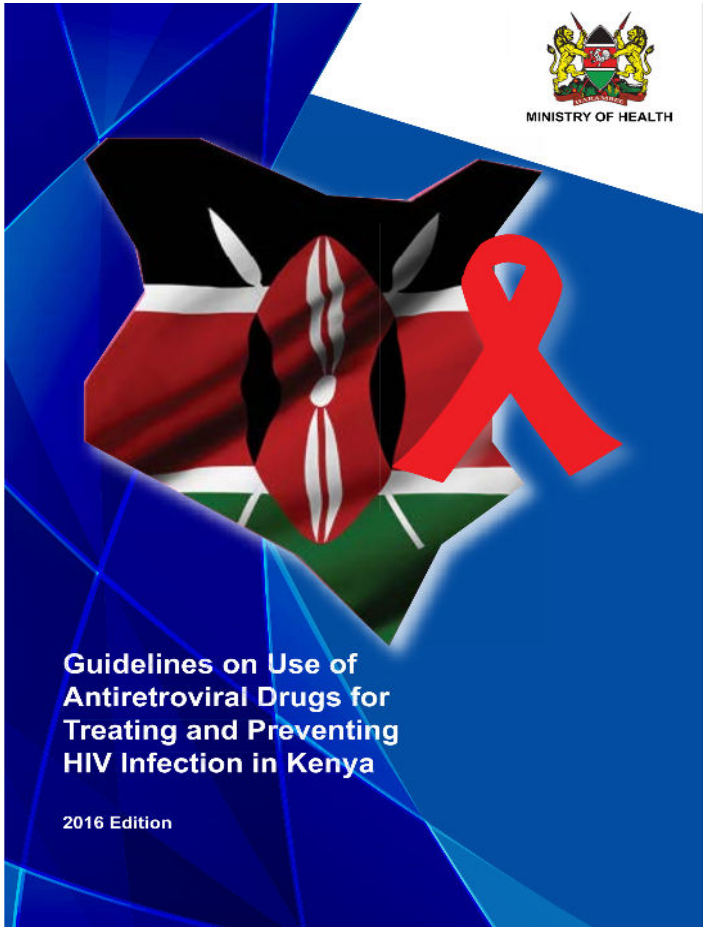
Differentiated Care for P@HR: Country Experience

- Scope of the Problem
- Treatment Guidelines
- Best Practices / Lessons Learned
- Differentiating Care for P@HR

Scope of the Problem

- Estimated 1.5 Million People Living with HIV in Kenya
- As at end May 2017 1,059,000 were on HIV treatment
- Of these, about 63,000 were on second line treatment and about 100 on third line treatment
- The Kenyan guidelines recommend test and start "Anza Sasa" regardless of immunological or clinical status
- Since 2014 viral load measurement recommended for routine treatment monitoring
- In 2016, 857, 000 viral load tests were done, 83% of these were suppressed (VL <1000copies/ml)

Kenyan Treatment guidelines



- Kenyan ART guidelines launched in July 2016
- Key guideline highlights
  - Test and start
  - Differentiated care
  - PrEP
- Package of care for patients with advanced disease
- Management of treatment failure – first and second line

Table 3.3: Differentiated Care Based on Initial Patient Presentation

Patients who Present with Advanced HIV Disease: WHO Stage 3 or 4, or CD4 count ≤ 200 cell/mm³ (or ≤ 25% for children ≤ 5 years old)	
Package of Care	• Standard Package of Care (Section 4) • Intensive management of presenting illnesses • Priority for identification, management and prevention of OIs • Priority for ART initiation • Close monitoring for development of immune reconstitution inflammatory syndrome (IRIS)
Location of Services	• Management at any ART service delivery point; all facility levels • Initial management and ART initiation by trained and experienced HCW • Consultation with MDT, TWG, mentors, and senior clinicians as needed (including telephone consultation such as Uliza! Clinicians' HIV Hotline) • Referral to a higher-level facility when feasible if consultation is not adequate to stabilize the patient
Focus of Treatment Preparation Counselling	• ART is required to prevent further damage to the immune system • Starting ART soon will decrease risk of disease progression, including wasting and OIs • ART is the most important treatment to restore health
Frequency of Follow-up	• Weekly follow-up until ART initiation, and then at week 2 and 4 after ART initiation, and then monthly until confirmed viral suppression • More frequent visits or hospitalization may be required to stabilize acute medical conditions and address psychosocial and other concerns

Table 3.5: Differentiated Follow-up of Patients Beyond the First Year of ART

Unstable Patients

Unstable Patients (any of the following):

- On their current ART regimen for < 12 months
- Any active OIs (including TB) in the previous 6 months
- Poor or questionable adherence to scheduled clinic visits in the previous 6 months
- Most recent VL ≥ 1,000 copies/ml
- Has not completed 6 months of IPT
- Pregnant or breastfeeding
- BMI < 18.5
- Age < 20 years
- Healthcare team has concerns about providing longer follow-up intervals for the patient*

Note: children and adolescents may be clinically stable, however they are not eligible for longer follow-up periods because of the need for weight-based dose adjustments and close monitoring of support systems.

Package of Care	• Standard Package of Care (Section 4) • Case management to address reason/s for not meeting stable eligibility criteria
Location of Services	• Management at any ART service delivery point; all facility levels • Consultation with MDT, CSC, mentors, and senior clinicians as needed (including telephone consultation with Uliza! Clinicians' HIV Hotline • Referral to a higher-level facility when feasible if consultation is not adequate to stabilize the patient
Focus of Counselling	• ART is the most important treatment to improve health and return to an active life • Targeted counselling to address reason/s they have not meet stable eligibility criteria
Frequency of Follow-up	• Every 1-3 months, based on clinical judgement and the specific reason/s they have not met stable eligibility criteria • Additional visits as required to address any medical or psychosocial concerns

Enhanced Adherence Support Interventions (for patients failing or at high-risk of failing treatment)	
Case management	• Assign a case manager to all children and adolescents (those not achieving optimum treatment outcomes); pregnant women, orphans, patients with alcohol and substance abuse, patients with mental illness, patients with suspected or confirmed treatment failure, and any patients who the healthcare team feels has poor adherence or is at high risk of defaulting from care • The case manager is the link between the patient and the MDT • Roles of the case managers include: - Coordinating multidisciplinary management for patients under case management - Following up on appointment-keeping for their patients - Organizing patient reminders (SMS, calling the day before) and other support systems - Ensuring appropriate defaulter tracing - Coordinating home visits to their patients
Directly observed therapy	• Patients with suspected treatment failure should have DOTs to ensure good adherence before a viral load is repeated to confirm treatment failure • DOTs involves a healthcare provider, family member, treatment supporter or any trained peer observing the patient ingesting their prescribed ART on a daily basis • DOTs can be tapered off once the patient adopts consistent adherence-enhancing behaviours and barriers to adherence are overcome

Figure 5.2: Adherence Counselling and Education for Patients Preparing to Initiate 2nd Line or 3rd Line ART

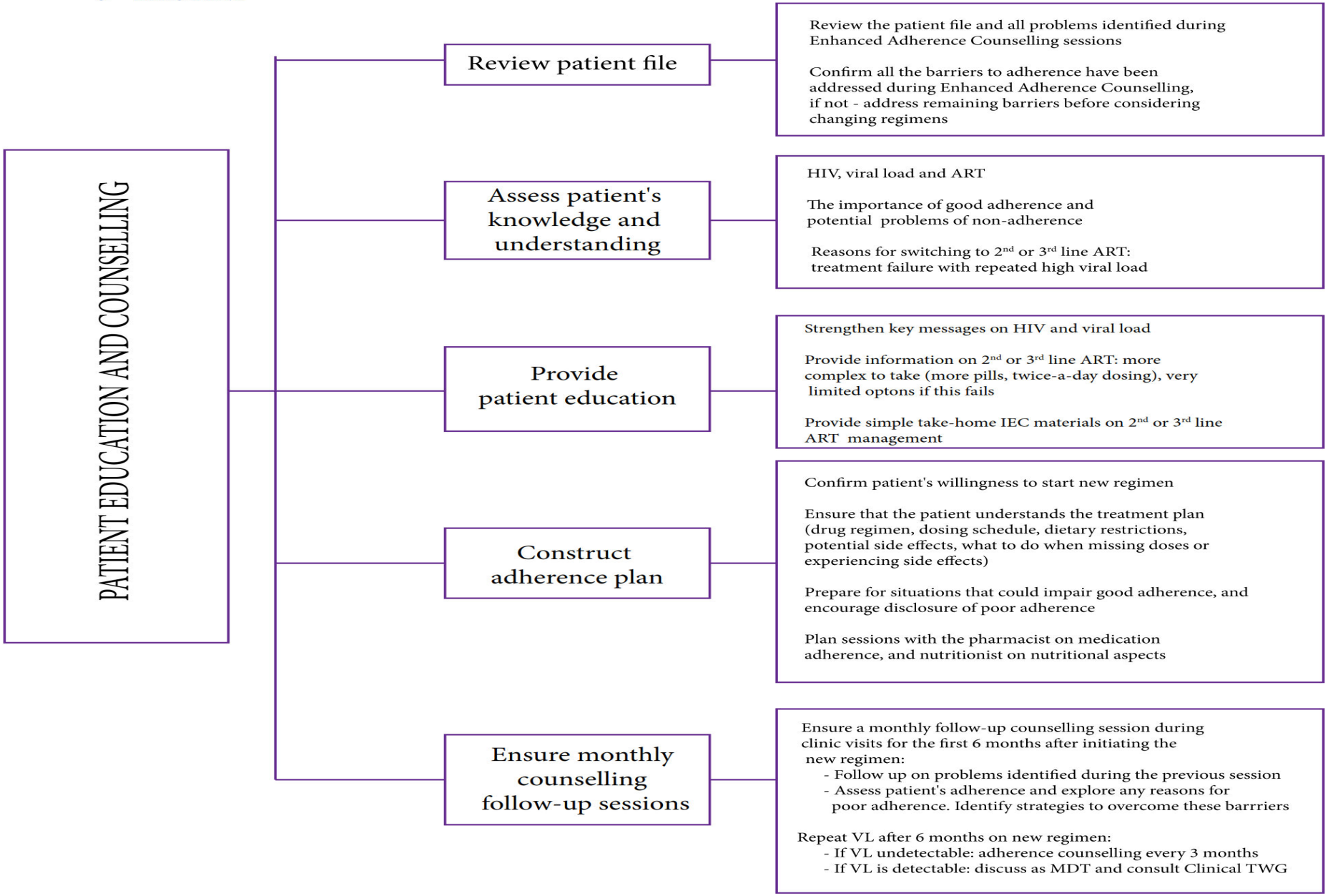
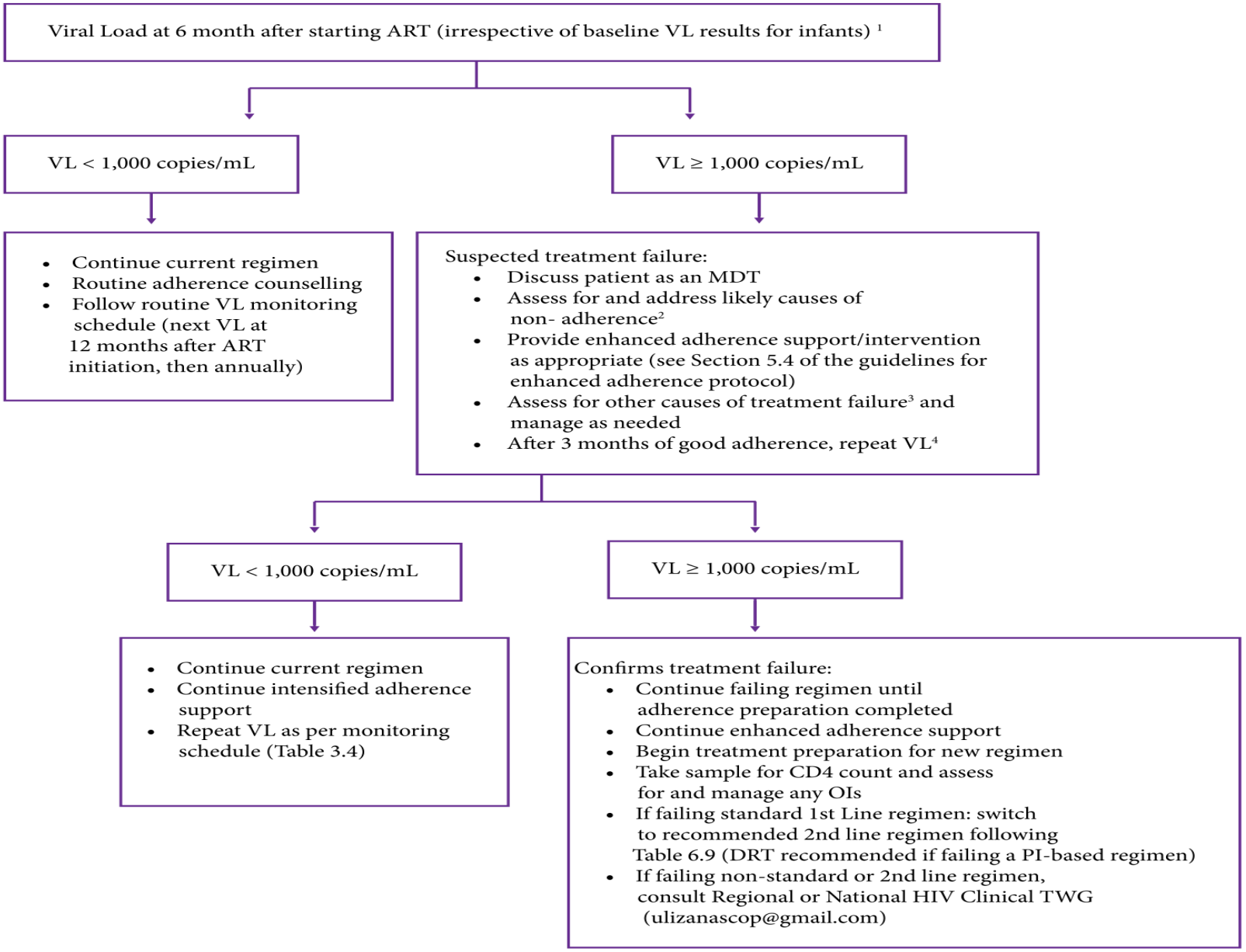


Figure 6.4: Viral Load Monitoring of Patients on ART (1st Line or 2nd Line)



Implementing Differentiated care

- Differentiated care operational guide developed
- Guide for health care workers and lay providers
- Guides on models of ART delivery for stable patients
  - Facility fast track
  - Community ART distribution

Best Practices / Lessons Learned

- Establishment of national HIV clinical support centre and regional clinical TWGs
  - Reduced clinical decision making for clinicians in peripheral sites through use of email and phone consults
  - Increased access to mentorship opportunities for HCWs
- Assignment of case managers for high risk PLHIV
- Partner led initiatives such as resistance clinic in AMPATH- supports high risk PLHIV

Differentiated Care for P@HR

- Mentorship support to enhance clinicians competency in managing complicated cases
  - Use of ECHO platform to provide virtual support to HCWs through regular CMEs
  - Use of regional clinical TWGs to provide support to facilities/HCWs managing high risk patients
- Build capacity of adherence counselors and peers
  - Enhance psychosocial support for PLHIV and their families
- Community and facility linkages to enhance support for high risk PLHIV

THANK YOU!
ASANTENI!